

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been injured, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Oliver AMOSS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-83</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		2b. HOUR <b>4 PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY, MD.</b>		
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD CT. GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAR OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>W. FRIENDSHIP</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Ramsey Amoss</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie C. Utz</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>0217327883</b>		17. INFORMANT ADDRESS <b>India Moyer - Wilmington, Del.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic cancer.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>83</b> , to <b>11/16</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/16</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>William Flowers MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/16/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm Flowers MD</b>				22e. ADDRESS <b>15802 Hickory Ridge Rd Columbia Md</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>11-19-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mariottsville Carroll Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>				ADDRESS <b>HAIGHT FUNERAL RT. 32 ELDERSBURG MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Conner</b>



RECEIVED

11-19-52  
Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.

11-19-52

Mr. J. Edgar Hoover

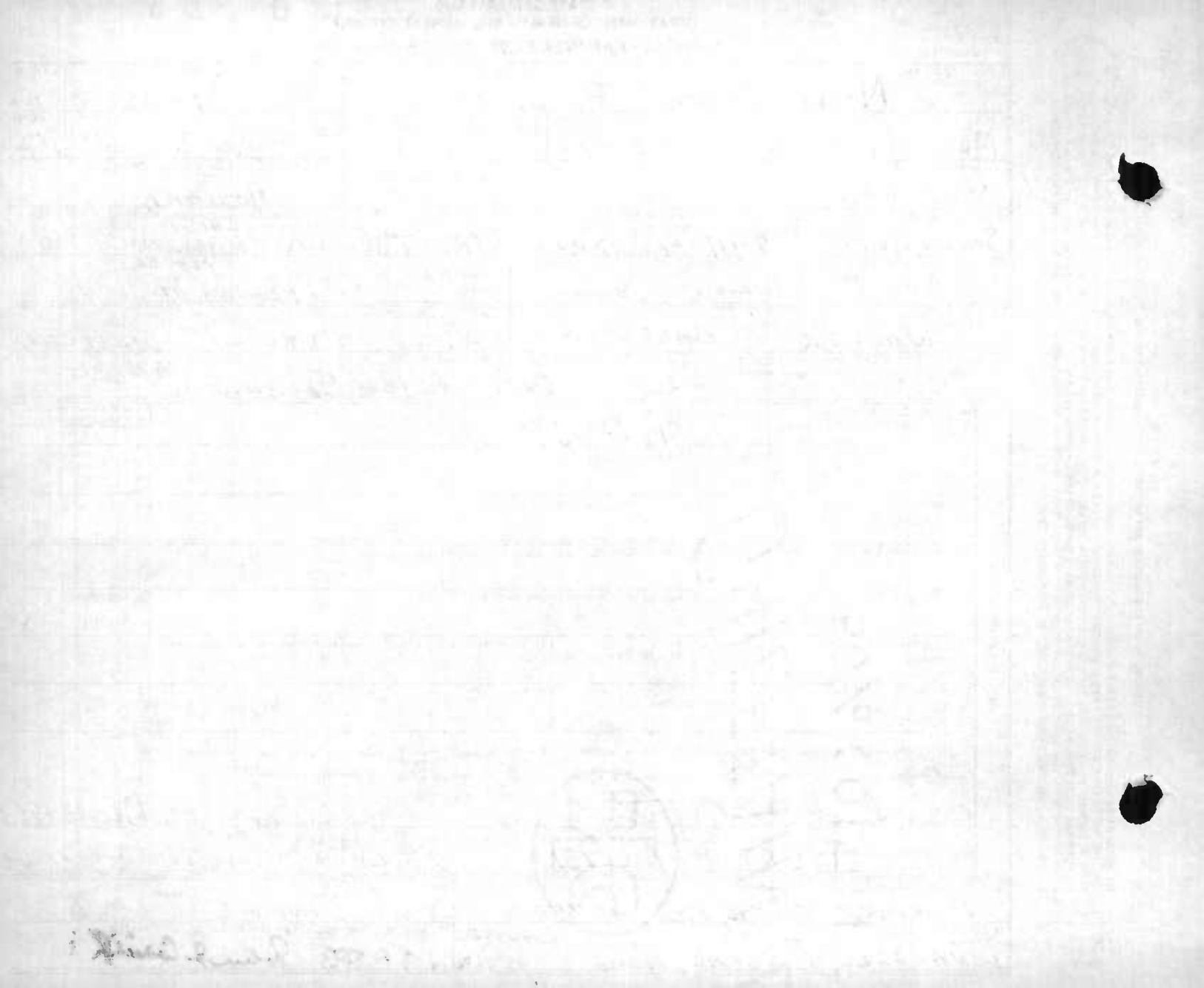
U.S. Department of Justice

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>NORRIS THOMAS BALDWIN</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>Nov</b> DAY <b>13</b> YEAR <b>1983</b>		2b. HOUR <b>3 A M</b>
3. SEX <b>MALE</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>JAN</b> DAY <b>6</b> YEAR <b>1934</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>49</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD <b>Nov 13</b> 19 <b>83</b>		2d. HOUR <b>9:00 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD.					
10. CITY OR TOWN OF DEATH <b>SAVAGE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8411 FOUNDRY STREET</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAKING INSTRUMENTS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>UN. of MD.</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>SAVAGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8411 FOUNDRY ST</b>				
14. FATHER'S NAME FIRST <b>WALTER</b> MIDDLE <b>BALDWIN</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>ADA</b> MIDDLE <b>REBECCA</b> LAST <b>WHEELER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-30-6451</b>		17. INFORMANT ADDRESS <b>ABOVE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCND.</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Bert F. Morton</b>						TITLE (SPECIFY)		DATE SIGNED <b>Nov 13, 1983</b>		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>						ADDRESS <b>2802 MONCLAIR DR. EL. 21043</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV 15, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SAVAGE CEM</b>				23d. LOCATION CITY OR TOWN <b>SAVAGE</b> COUNTY <b>MD</b> STATE <b></b>				
24. FUNERAL DIRECTOR NAME <b>DONALDSON FUNERAL HOME</b> ADDRESS <b>LAUREL</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Smith</b>						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
JAMES		A.		BOYLAN	November		14,	1983	12:30A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		June 19, 1899		84		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U.S.A.				Howard County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Lorain Nureing Home				accountant		Western Electric			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE	
New York		Westchester		Scarsdale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		34 Byron Pl.		10583	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Thomas Boylan				Annie McIntegert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. CITY		20. STATE	
Yes		WW 1		085-01-7008		Mrs. Joan R. Mancusi, Gaithersburg, Md.		1533 Tanyard Hill Road		20879	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Metastatic Cancer											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22. I certify that (I) (this hospital) attended the deceased from 11/10/83 to 11/17/83, that (I) (we) last saw the deceased alive on 11/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
John C. Prude, MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
John C. Prude				10780 Hickory Ridge Rd, Col. Md 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		11/17/83		Gate Of Heaven Cemetery		Hawthorne				N.Y.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Leroy P. & Russell C. Witzke Funeral Homes P.A.				NOV 15 1983				John J. G... ..			
5555 Twin Knolls Road, Columbia, Maryland 21045											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
JOHN J. BRENNAN					11 20 83					7 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
MALE		WHITE		05 26 23		60 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK		U.S.A.				HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ELLICOTT CITY		9424 DUNLOGGIN ROAD, 21043				POLICE LT.		CITY OF BALTIMORE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		HOWARD		ELLICOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9424 DUNLOGGIN ROAD, 21043			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
WILLIAM BRENNAN					ELIZABETH McGUINNES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES WW II					050-18-0907		MARY J. BRENNAN 9424 DUNLOGGIN ROAD, 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 7330 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Choke, foreign, severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-2 19 76 to 11-20 19 83, that (I) (we) last saw the deceased alive on 5-22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Philip Moore</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-22-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
PHILIP MOORE, M.D.						3925 BEECH AVENUE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				11-23-83		CREST LAWN MEM. GAR.		MARRIOTTSTVILLE HOWARD MD.			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC.				4107 WILKENS AVE.		21229		NOV 23 1983 <u>John J. Lawler</u>			

BP

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Item 13 phone 11/30/83 dad STATE OF MARYLAND  
 1- FOR Item 7a film#G607- DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR 9-18-85 TRINIDAD DE HARO CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>TRINIDAD DE HARO</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>26</b> YEAR <b>83</b>			2b. HOUR <b>8:45</b> P.M.				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>20</b> YEAR <b>13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Venezuela</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Venezuela</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD				
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GEN HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Venezuela</b>		13b. COUNTY <b>Caracas</b>		13c. CITY OR TOWN <b>Los Pinos Grandes</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST <b>Miguel</b> MIDDLE <b>Velazquez</b> LAST <b>garcia</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Angeles</b> MIDDLE <b>garcia</b> LAST <b>garcia</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>1421 ARLWOOD Road</b> <b>Jose' A. Tufano</b> <b>Catonsville, Md. 21228</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>1540</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Colorectal metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>none</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<b>Peripheral arterial emboli</b>										
19a. DATE OF OPERATION <b>11/26/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arterial emboli</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1; OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) this hospital attended the deceased from <b>11/26/83 11/26/83</b> to <b>11/26/83</b> that (b) the last saw the deceased alive on <b>11/26/83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan G. Stahl, MD</b>		22c. ADDRESS <b>Columbia Medical Plan</b>		22d. DATE SIGNED <b>11/26/83</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cementerio Del Estes</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Caracas Venezuela</b>				
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

Handwritten notes at the top of the page, including a date "11/22/83" and some illegible text.

Handwritten notes in the middle section, possibly a list or a set of instructions.

Handwritten notes in the lower middle section, including the date "11/22/83" and some illegible text.

Handwritten notes at the bottom of the page, including a date "11/22/83" and some illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Stanley E DORSEY</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>11 18 83</u>		2b. HOUR <u>6 A.M.</u>	
3. SEX <u>MALE</u>		4. RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11 21 16</u>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <u>66</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Columbia</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard County General Hospital</u>		12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) <u>Bus. Driver</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Howard</u>		13c. CITY OR TOWN <u>West Friendship</u>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Andrew Dorsey</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Florence Powell</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>WW II</u>		16b. SOCIAL SECURITY NO. <u>216-12-5821</u>	
17. INFORMANT ADDRESS <u>Carol Burgess (sister) 16108 Crabbs Br. Derwood, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lower GI Bleeding</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>11-17</u> , 19 <u>83</u> , to <u>11-18</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11-18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Francis Bruno</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-18-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANCIS BRUNO MD</u>		22e. ADDRESS <u>Columbia, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>11-22-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cookesville Howard Md.</u>	
24. FUNERAL DIRECTOR NAME <u>George R. Snowden</u>		ADDRESS <u>246 N. Wash. St. Rockville, Md.</u>		DATE RECD. BY REGISTRAR <u>NOV 22 1983</u>		SIGNATURE <u>John J. Conner</u>	

BP \_\_\_\_\_

Nov 28 1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES E. FARNANDIS</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11-22-83</b>		2b. HOUR <b>3:15 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1, 1966</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>17</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD <b>11-22-83</b> 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Howard</b>		13c. STREET ADDRESS <b>6202 Old Columbia Road 21044</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>W. Walter Farnandis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara A. Howren</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-54-8107</b>		17. INFORMANT ADDRESS <b>W. Walter Farnandis Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Craneo-cerebral injury</b> IMMEDIATE CAUSE (a) <b>8/22</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>2:45 PM 11-22-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of motorcycle which struck a turning truck running into the rear</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>intersection of</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Blue Arrow &amp; Quarterstaff Howard Co. Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Dennis F. Smyth</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>11-23-83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Md.</b>		STATE	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
1630 Edmondson Avenue, Catonsville, Md. 21228					

COMMUNICATIONS SECTION  
U.S. AIR FORCE

Jan. 1, 1953

U.S.A.

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43817-10-10



Groundwater Company

1000 S. 1st St., Suite 100, Phoenix, Ariz. 85001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR <b>JOHN HENRY FELTHAM</b>				20. DATE OF DEATH MONTH DAY YEAR 11-16-83 519 <sup>PM</sup>			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN HENRY FELTHAM</b>		2. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR 10-6-02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier-Aist.-Sect. Garrett &amp; Sons</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Robert</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Feltham</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Horsefall</b>		13e. STREET ADDRESS <b>4013 Spring Meadow Drive 21043</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-05-2242</b>		17. INFORMANT ADDRESS <b>Mrs. Elizabeth L. Feltham Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>3580</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Crises</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>83</b> , to <b>11/16</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/6/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Judith Minkove</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Judith Minkove</b>		22e. ADDRESS <b>5755 Cedar Ln, Columbia, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>11/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James E. Carver</b>	

BP \_\_\_\_\_



DO NOT WRITE IN THESE SPACES

RECEIVED

General County

General County

Robert

General County, General County, General County

General County

General County, General County, General County

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General County

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General County



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Barbara		MIDDLE Flaum		LAST Flaum		20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11/6/83 19		21. HOUR M 11:20 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 25, 1940		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 11/6/83 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE PENNA.		13b. COUNTY BUCKS		13c. CITY OR TOWN FAIRLESS HILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 517 CASSINGHAM RD. (19030)			
14. FATHER'S NAME ADOLPH				MIDDLE MEISNER		15. MOTHER'S MAIDEN NAME FAY				MIDDLE SILVERGATE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 1901 FLATBUSH AV BOULEVARD-PARK WEST CHAPELS BKLYN, N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) Hanging Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY BETWEEN 9:30 & 10:00AM 11/6/83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7158 Winter Rose Path, Columbia, Howard, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 11/7/83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St, Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL BURIAL/REMOVAL				23b. DATE 11/9/83		23c. NAME OF CEMETERY OR CREMATORY BE TH DAVID, E.				23d. LOCATION CITY OR TOWN COUNTY STATE ELMONT, LONG ISLAND, N.Y.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. Baltimore, md. (21215)						25a. DATE REC'D. BY REGISTRAR NOV 10 1983		25b. REGISTRAR'S SIGNATURE John J. Corbett			

REPLY NOTICE

MS  
MS  
MS  
MS



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR <b>BERNICE HARVIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 6 83</b>		2b. HOUR <b>3:00 PM</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>BERNICE</b>		3. SEX <b>Female</b>		4. RACE <b>Black</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>		10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Special Ed.</b>		13a. STREET ADDRESS <b>21045</b>	
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Hervin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Ragins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>105-22-2595</b>		17. INFORMANT ADDRESS <b>Columbia, MD. 21045</b>		17. INFORMANT NAME <b>Mrs. Katura Weatherspoon-5451 High Tor Hill</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Lung metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchial asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1629</b> <b>years</b> <b>months</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>11-3-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fiberoptic Bronchoscopy and Biopsy.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-13</b> 19 <b>83</b> to <b>11-6</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11-6</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John L. Lewis</b>		DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>11/6/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John L. Lewis, M.D.</b>		22e. ADDRESS <b>10802 Hickory Ridge Rd, Col, Md 21044</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>			
24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		25. REGISTRAR'S SIGNATURE <b>John L. Lewis</b>			
5555 Twin Knolls Rd., Columbia, MD. 21045					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

WILLIAM H. HARRIS

WILLIAM H. HARRIS

Female

Wick

1900-1901

Howard County

Female

Wick

Howard County General Hosp. School of Nursing

Columbia

1900

Howard County General Hosp. School of Nursing

Columbia

Howard

Female

Howard

Wick

Wick

Female

Howard County General Hosp. School of Nursing

1900-1901

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Howard County General Hosp. School of Nursing

Female

Wick

Howard

Howard

1900

Howard County General Hosp. School of Nursing

1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

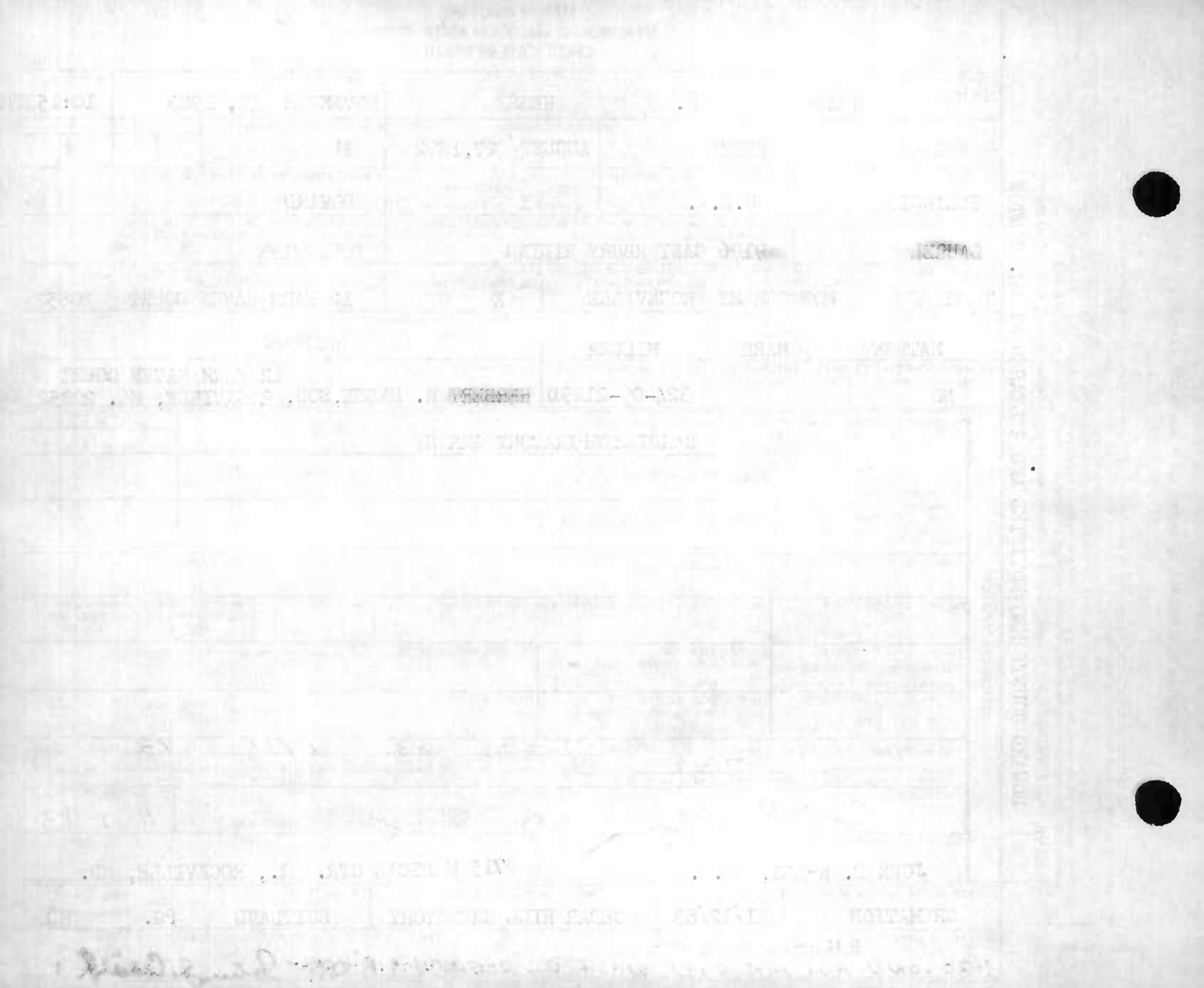
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or checked (B) below, any injury, or other traumatic event, the medical examiner must be notified at once.

HOWARD COUNTY MEO NOTIFIED AND RELEASED BY DR. MONTON

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GRACE M. HESSE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 11, 1983</b>		2b. HOUR <b>10:15<sup>AM</sup> PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 27, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD.	
10. CITY OR TOWN OF DEATH <b>LAUREL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9196 CANTERBURY RIDING</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MATHEW MARK MILLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		13e. STREET ADDRESS / ZIP CODE <b>12 FARM HAVEN COURT 20852</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>324-09-2189D</b>		17. INFORMANT ADDRESS <b>HERBERT R. HESSE, SON, 12 FARM HAVEN COURT, ROCKVILLE, MD. 20852</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-27</b> , 19 <b>83</b> , to <b>11/11</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>7-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John E. Kelly</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-12 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. KELLY, M.D.</b>		22e. ADDRESS <b>9715 MEDICAL CTR. DR., ROCKVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>11/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PG. MD</b>	
24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP INC.</b>		ADDRESS <b>1120 CONN. AVE. N.W. #940, WASH. D.C. 20036</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>		25b. REGISTRAR'S SIGNATURE <i>James G. Bailey</i>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR **HELEN RUTH KIDD**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN RUTH KIDD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 8, 1983</b>			2b. HOUR <b>8<sup>20</sup></b> P. M.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 29, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk - Social Security</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>13450 Forsythe Road 21784</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DeVane Sibley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Flanigan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-30-4817</b>			17. INFORMANT ADDRESS <b>13450 Forsythe Road - P.O. Box 131 Mr. Charles L. Kidd Sykesville, Md. 21784</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <b>4254 Ventricular asystole</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart failure</b>		<b>months</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive cardiomyopathy</b>		<b>years</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

**Rheumatic heart disease**

19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Nov. 8</b> , 19 <b>83</b> , to <b>Nov. 8</b> , 19 <b>83</b> , that (1) (we) lost <b>Nov. 8</b> , 19 <b>83</b> , and that (1) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <b>William Parnes, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM PARNES</b>				22e. ADDRESS <b>11085 Little Patuxent Pkwy, Columbia Md. 21044</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/11/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Md.</b>	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1940

UTM

County

U.S.A.

North Carolina

North Carolina - Raleigh

Howard County General Hospital

Columbia

1000 Forsyth Road, Raleigh

Y. Smith

Howard

Admission

Room

Private

Columbia

1000 Forsyth Road, Raleigh, N.C. 27601  
Dr. Charles L. King, M.D.

Dr. Charles L. King



Admission

Room

Private

1000 Forsyth Road, Raleigh, N.C. 27601  
Dr. Charles L. King, M.D.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret T Lee</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>17</b> YEAR <b>83</b>			2b. HOUR <b>8:00 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>01</b> DAY <b>05</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>COOKSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 39 21723</b>	
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>Wilson</b> LAST <b>Thomas</b>		15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>Sarah</b> LAST <b>Brown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>Dorothy Lee Ellicott City, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). <b>DIABETES MELLITUS</b>									
19a. DATE OF OPERATION <b>10-29-83 AND 11/6/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CANCRENE OF THE LEFT FOOT DUE TO OCCUSION OF THE SUPERFICIAL FEMORAL ARTERY</b>		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-27-1983</b> to <b>11-17-1983</b> , that (I) (we) lost saw the deceased alive on <b>11/16/1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>GARTH A-S. SAMUELS</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-17-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARTH A-S. SAMUELS</b>		22e. ADDRESS <b>6911 PARK HEIGHTS AVE BALTIMORE MD 21215</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bushy Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cooksville Howard Md</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W Haight</b>		ADDRESS <b>Sixesville</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>			

This certificate must be signed by the medical examiner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30438

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DELOSS MONTONEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 14 83</b>			2b. HOUR <b>P.</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 1 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5724 Miami Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Grayhound Bus</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Elkridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5724 Miami Court 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert M. Montoney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Roby</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>577-18-3034</b>		17. INFORMANT ADDRESS <b>Louise R. Montoney 5724 Miami Court 21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hyper-Chronic Obstructive Pulmonary Disease, CHF</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-23</b> , 19 <b>81</b> , to <b>10-28</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10-28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Glen Robbins</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-15-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Glen Robbins</b>				22e. ADDRESS <b>1404 Crain Hwy. Suite 3</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/18/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>			

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Metastatic Carcinoma of Lung

Right Chronic Obstructive Pulmonary Disease C46

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LEO G. MULHEARN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/1/83</b>		2b. HOUR <b>1 P.M.</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2/28/18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65-6-5</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y. USA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A. USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia Md</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Hosp. - Menom -</b>		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Manager</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY UNITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>6601 QUIET HRS 21045</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo B. Mulhearn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Stoessel</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>		16b. SOCIAL SECURITY NO. <b>027-16-3804</b>		17. INFORMANT <b>6601 Quiet Hrs. - Apt. T-2#21045</b> <b>Mr. Leo Barry Mulhearn - Columbia, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 7331 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<b>Fracture Hip</b>					
19a. DATE OF OPERATION <b>10/1/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/1/83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Fractured hip</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/1/83</b> to <b>11/1/83</b> , that (I) (we) lost saw the deceased alive on <b>10/31/83</b> , and that in (my) (our) <b>death</b> occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mark Davis</b>		22c. DATE SIGNED <b>11/1/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK DAVIS</b>	
22e. ADDRESS <b>9051 BART MAF</b>		22f. ADDRESS <b>9051 BART MAF</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Milton Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boston, Mass.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>			
24. FUNERAL DIRECTOR <b>G.T. Schwab</b>		5151 Balto. Nat'l. Pike #21229		25. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR  
**ELLA RUTH PEGUES**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA Ruth Pegues</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-8-83</b>			2b. HOUR <b>4:27</b> AM			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-20-05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10609 New Moon Place, 21044</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Bailey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Watson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>257-56-0625</b>		17. INFORMANT ADDRESS <b>Jacquelin P. Hall same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METABOLIC ENCEPHALOPATHY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>26 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-13</b> , 19 <b>83</b> , to <b>11-8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11-7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Krishna P. Kumar</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHNA P KUMAR</b>				22e. ADDRESS <b>HOWARD COUNTY GENERAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Griffin Moore Gardens Griffin</b>		23d. LOCATION CITY OR TOWN STATE <b>Spaulding GA</b>			
24. FUNERAL DIRECTOR <b>Leroy M. C. Russell C. Witzke</b> <b>5555 Twin Knolls RD. Columbia, MD. 21045</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 4 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Thomas Milo Peters, Sr.</b>		2a DATE OF DEATH MONTH DAY YEAR <b>November 25, 1983</b>		2b HOUR <b>9<sup>07</sup> A M</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 9, 1907</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Div. Manager</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>Sears Roebuck &amp; Co.</b>		13a STREET ADDRESS <b>2818 63rd. Place 20785</b>			
13b USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13c CITY OR TOWN <b>P.G. Chervy</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>577-03-5919</b>		17 INFORMANT ADDRESS <b>6406 Woodsong Ct. Mr. Kenneth S. Peters McLean, Virginia</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>4290</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CARDIOGENIC SHOCK</b> (c) <b>CONGESTIVE HEART FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 mins.</b> <b>sev. hours</b> <b>sev. yrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>82</b> , to <b>11/25</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Stephen A. Valentini</b>		DEGREE <b>PHYSICIAN</b>		22c DATE SIGNED <b>11/25/83</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN A. VALENTINI</b>		22e ADDRESS <b>Howard County General Hospital</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Nov. 28, 1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>		24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>			
25a DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NOV 207

SAUS (Sausage)  
T. Kenneth R. Peters, Virginia

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Nov. 10, 1941. Received from T. Kenneth R. Peters, Virginia  
T. Kenneth R. Peters, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Carrie Bell Pierce</b>			2a. DATE OF DEATH		MONTH DAY YEAR <b>11 / 12 / 83</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 / 14 / 88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.
7a. BIRTHPLACE (COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien Nursing &amp; Convalescent Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Brunswick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Webster Main</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriett Isabelle Caskey</b>		13e. STREET ADDRESS <b>914 E. Street</b>		<b>21716</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-48-6271</b>		17. INFORMANT ADDRESS <b>Daisy Decker - Brunswick, Md. 21716</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration</b> <b>4290</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Organic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>						
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:00 P.M. 11 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>None</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>None</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>None Brunswick, Frederick, Md.</b>		
21g. I certify that (I) (this hospital) attended the deceased from <b>12 Nov 83</b> , 19 <b>83</b> , to <b>12 Nov 83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>12 Nov 83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12 Nov 83</b>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. ADDRESS <b>Lorien Nursing Home</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brunswick, Frederick, Md.</b>
24. FUNERAL DIRECTOR NAME <b>John T. Williams Funeral Home Brunswick, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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NOV 17 1955

John F. Kennedy Library, Boston, Massachusetts



G#586 12/12/83 mtb items #15

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 4 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR													
James A. Ralston								November 27, 1983										M													
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				IF UNDER 24 HRS															
Male		White		August 16, 1926				57				YRS.				MONTHS				DAYS				HOURS				MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																							
Maryland		U.S.A.						Howard County MD.																							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																													
Ellicott City		3042 Fawnwood Drive																													
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																													
Salesman																															
13a. STATE																		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland																		Howard		Ellicott City				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3042 Fawnwood Dr. 21043					
14. FATHER'S NAME																		15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST																		FIRST MIDDLE LAST													
Thomas Ralston																		Martha Lee Drury													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)																		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
Yes																		WW 11		Mrs Patricia Ralston 3042 Fawnwood DR 21043											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SMALL CELL CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1/a																															
19a. DATE OF OPERATION																		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
																						YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>83</u> , to <u>11/27</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)																															
22b. SIGNATURE <u>Thomas Brown</u> MD																		DEGREE				22c. DATE SIGNED <u>11/29/83</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas Brown</u>																		22e. ADDRESS <u>600 N WOLFE ST</u> <u>BALTIMORE MD 21205</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)																		23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial																		Dec 1, 1983				Crestlawn				Howard Maryland					
24. FUNERAL DIRECTOR NAME																		25. DATE RECEIVED BY (PARTIAL)				25b. SIGNATURE									
Harry H Witzke 4112 Columbia Rd Ellicott City																		Nov 30 1983													

MEDICAL CERTIFICATION

2  
10-11

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



November 27, 1953

James A. Kaitson

Male

White

August 10, 1950

27

Maryland

U.S.A.

Howard County

Ellicott City

3041 Farmwood Drive

Salesman

Maryland

Howard

Ellicott City

X

3041 Farmwood Dr. 21043

late Thomas Kaitson

late Martha Lee

Yes

WM II

116 10 1942

Mrs Patricia Kaitson 3041 Farmwood Dr 21043



Initial

Dec 1, 1953

Continued

Harry W. Weiska 4111 Columbia Rd Ellicott City

NOV 30 1953

Howard Kaitson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn Ruth Reed</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 8, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept 20, 1909<sup>R</sup></b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>	
10. CITY OR TOWN OF DEATH <b>Glenwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3021 Route 97 21738</b>		12a. USUAL OCCUPATION (TYPE AND WORKING PART OF WORKING INDUSTRY) <b>Retired saleslady</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Glenwood</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Houseman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>				16b. SOCIAL SECURITY NO. <b>214 22 8471</b>		17. INFORMANT ADDRESS <b>Mrs Sandi Collins 3021 Route 97 21738</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Longstanding coronary artery disease. years.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive heart failure.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION <b>9/12/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4100</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>9/12/83</b> , 19 <b>83</b> , to <b>11/8</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>9/12/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Brad J. Cooper, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRAD J. COOPER, M.D.</b>				22e. ADDRESS <b>3459 St. John's Ln. Ellicott City, MD 21043</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 10, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cooper</b>	

BP

HARRY H WICKS  
 Nov 10, 1901  
 Baltimore Maryland

Baltimore Maryland

NOV 10 1901

114 22 5471 Mrs Sarah Collins 3021 Route 97 21738

face

Maryland

Howard

Glenwood

x

3021 Route 97

21738

Glenwood

3021 Route 97

21738

Retired saleslady

Howard County

U.S.A.

xx

Female

White

Sept 10, 1900

74

November 6, 1901

Evelyn Ruth Reed

TO HOSPITAL, ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Page 3, if used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30445

REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Hubert Rule		2a. DATE OF DEATH MONTH DAY YEAR 11/24/83		2b. HOUR 4:35 P.M.	
3. SEX m		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 9 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST [unclear]		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST [unclear]		13e. STREET ADDRESS 5568 Montgomerie Rd		21227	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unk		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234 10 6315		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure. 4920 DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) [unclear] PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Bronchitis, chest wall contusion							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 P.M. 11/13 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Motor Vehicle Accident			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Howard, Md.			
22a. I certify that (I) (this hospital) attended the deceased from 11/13 1983 to 11/24 1983, that (I) (we) last saw the deceased alive on 11/24 1983, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William Flowers		DEGREE MD		ATTENDING PHYSICIAN MEDICAL EXAMINER <input type="checkbox"/>		22c. DATE SIGNED 11/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm Flowers MD		22e. ADDRESS 10802 Hickory Ridge Rd Columbia Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/25/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR NOV 29 1983		25b. REGISTRAR'S SIGNATURE John J. Conick	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Eleanor W. Sapp		2a. DATE OF DEATH MONTH DAY YEAR November 30, 1983		2b. HOUR 5:25 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 7 915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien N.H./6334 Cedar Ln.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel S. Wheat		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Walsh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-46-3362	
17. INFORMANT ADDRESS 4015 Bedford 07		17. INFORMANT Nannie C. Lawler		17. INFORMANT Baltimore, Md. 212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>Cerebral-pulm aneur</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> CD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15/83</u> to <u>11/30/83</u> that (I) (we) lost saw the deceased alive on <u>11/30/83</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. Ellis Seals</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Ellis Seals, M.D.		22e. ADDRESS 11085 Little Patuxent Pkwy 21044					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/1/83		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore, Md	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

1- FOR  
STATE  
REGISTRAR

GEORGIA KALEEN SAWYER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30441

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Georgia K. SAWYER</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-19-83</i>			2b. HOUR <i>1100 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 29 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i> MD	
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Head Cashier</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Ellicott City</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas H. Brown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie Kendall</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>							
16b. SOCIAL SECURITY NO. <i>215-01-2104</i>				17. INFORMANT <i>13111 Heiton Terrace</i> <i>Mr. Richard Kight Baltimore, Md. 21228</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Cardiopulmonary Arrest*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Acute Myocardial Infarction*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*Instant**Weeks*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 5</i> 19 <i>83</i> to <i>Nov. 19</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Nov. 19</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Geoffrey I. Levine</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/19/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Geoffrey I. Levine, M.D.</i>				22e. ADDRESS <i>10802 Hickory Ridge Rd. Columbia, Md. 21044</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/22/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crestlawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Marriottsville Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>LeRoy M. &amp; Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1983</i>	
						25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

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U.S. - 1944

1944

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21-07-2104 Mr. Richard M. Hill, Baltimore, Md. 21228

21-07-2104 Mr. Richard M. Hill, Baltimore, Md. 21228

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30448

1- FOR  
STATE  
REGISTRAR

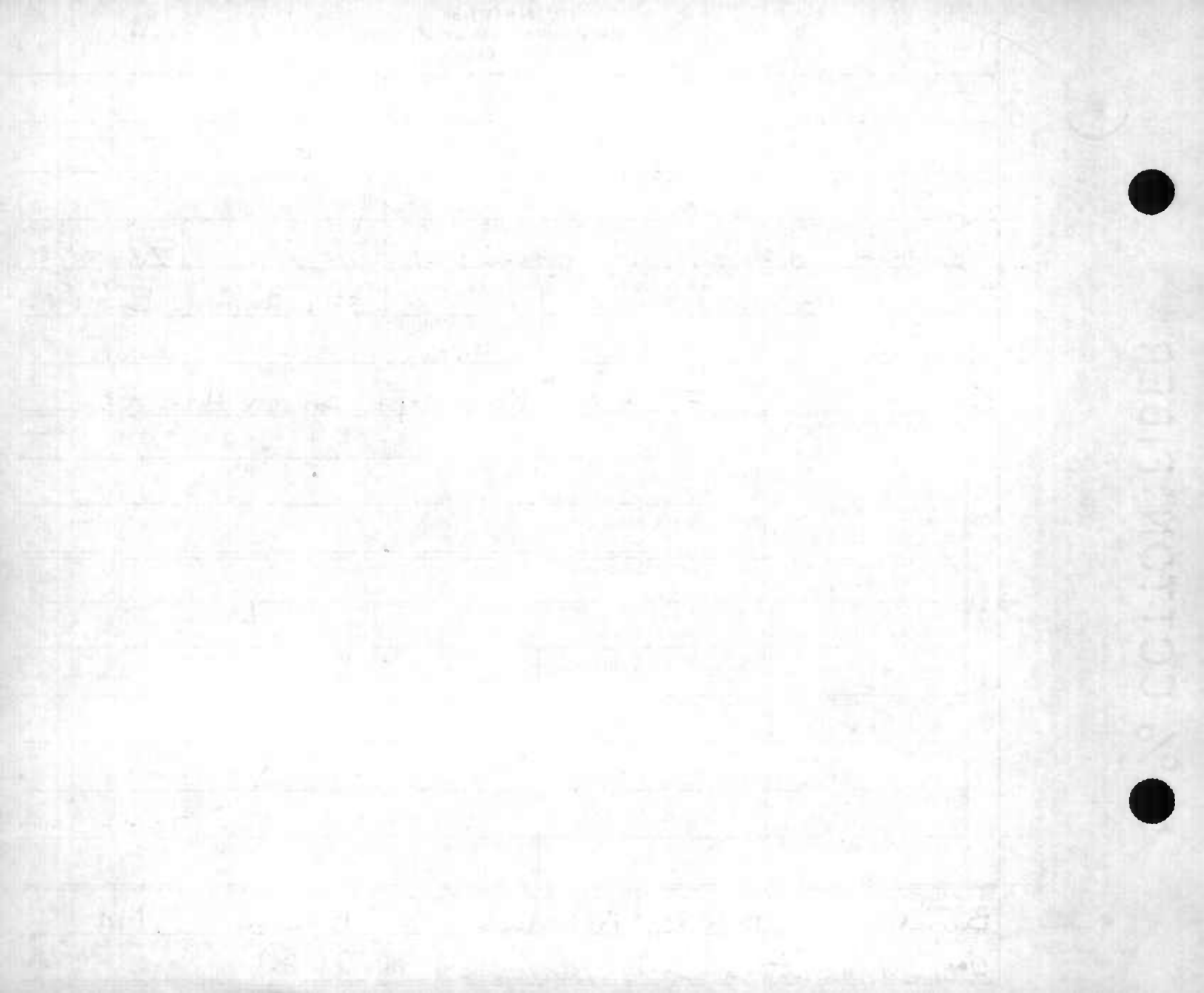
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie Smith			2a. DATE OF DEATH MONTH DAY YEAR 11 25 83		2b. HOUR 8 50 P.M.
3. SEX Female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 9 29 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN	12b. KIND OF BUSINESS OR INDUSTRY MARTINS	
13a. STATE md			13b. COUNTY HOWARD	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Severn Trinner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Jacob		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-16-0413		17. INFORMANT ADDRESS Bernadetta Smith Holbrook	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ovarian Carcinoma, stage 4</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a NIP					
19a. DATE OF OPERATION NIP		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NIP		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-24, 19 83, to 11-25, 19 83, that (I) (we) lost saw the deceased alive on 11-25, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donna Myers				22c. DATE SIGNED 11-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna Myers				22e. ADDRESS 70 Howard Co. General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-30-83		23c. NAME OF CEMETERY OR CREMATORY Arbutus	
23d. LOCATION CITY OR TOWN BALTO.		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME James L. ...		ADDRESS 1070 Lawrence St		25a. DATE REC'D. BY REGISTRAR NOV 28 1983	
25b. REGISTRAR'S SIGNATURE John J. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30449

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH JANE SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-27-83</b>			2b. HOUR <b>22<sup>10</sup></b> M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01-30-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.				
10. CITY OR TOWN OF DEATH <b>Columbia Ho. Cty. Gen Hosp.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8360 main St 21043</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late George Roy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Maude Collins</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Boyd E. Smith 8360 Main St Ellicott City</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC Arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Prophylactic. Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Long CARCINOMA.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> , 19 <b>83</b> , to <b>11/28</b> , 19 <b>83</b> , that (I) (we) lost <b>know the deceased alive by</b> <b>above</b> (I) (we) (did) (did not) <b>know the body after death</b> <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <b>Jeffrey H. Peters</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>11/28/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey H. Peters</b>					22e. ADDRESS <b>Howard Carr General.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City Howard Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke 4112 Columbia RD Ellicott City</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

BP

JANE SMITH

West Virginia

Revised

1900

Late George Roy

No

Late George Roy

1900-1901

Nov 30, 1903 Nov 30, 1903 Nov 30, 1903

Nov 30, 1903 Nov 30, 1903 Nov 30, 1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30450			
1. DECEASED NAME (TYPE OR PRINT) <b>Victoria G. Smith</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 7, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 25, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>	
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3725 Springmeadow Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Emil Gathmann</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Isabelle Gary</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr Gary Smith 3725 Springmeadow Dr. 21043</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Plasmodic Carcinoma of Colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>82</b> , to <b>Nov 7</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>July</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) saw the body after death.)							
22b. SIGNATURE DEGREE <b>Lawrence Swink</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-7-83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE SWINK</b>				22c. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 8, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>		4112 Columbia Rd Ellicott City		25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

November 7, 1983

Victoria G. Smith

83

May 25, 1983

White

Female

U.S.A.

Howard County

xx

Female

Homestead

3725 Springmeadow Drive

Ellicott City

3725 Springmeadow Dr. 21043

x

Ellicott City

Howard

Maryland

Late Isabelle Gary

Late Emil Gashman

Mr Gary Smith 3725 Springmeadow Dr. 21043

No

Ellicott City Maryland

Nov 8, 1983 Portaine Park

11/11/83

4113 Columbia Rd Ellicott City

Harry H. Wicks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 after be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30451

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Edith M. Stapf</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Nov 22, 1983</b>		2b HOUR <b>8:48 PM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>April 7, 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Ellicott City</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OR PRINT, CITY, STREET ADDRESS) <b>8198 Main Street 21043</b>		12a USUAL OCCUPATION (TYPE OR PRINT, NATURE OF WORKING LIFE) <b>Retired</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Florist</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Howard</b>	13c CITY OR TOWN <b>Ellicott City</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>late John Sheppard</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Mary Sheppard</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>217 07 3877A</b>	17 INFORMANT ADDRESS <b>Frank J Stapf 8198 Main St. Ellicott City</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive A.S.C.V.D.</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>2-28</b> , 19 <b>58</b> , to <b>11-22</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased on <b>11-22</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Thomas R. Herbert, M.D.</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>11-22-83</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. F. Herbert, MD</b>		22e ADDRESS <b>Ellicott City, MD 21043</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Nov 25, 1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>St Johns</b>	
24 FUNERAL DIRECTOR'S NAME <b>Harry H Witzke</b>		ADDRESS <b>4112 Columbia Rd Ellicott City</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>	
25b REGISTRAR'S SIGNATURE <b>John L. Conner</b>					

MEDICAL CERTIFICATION

9



Nov 22, 1983	Edith M. Stapp	Female	White	April 7, 1936	67
Howard County	U.S.A.	Maryland			
Retired	21043	Ellicott City	8198 Main Street		
Florida					
21043		Howard	Ellicott City		
8198 Main St					
Shepard					
21043					
Frank J. Stapp	217 07 3872A	Jane John Shepard			
8198 Main St. Ellicott City					

Barry H. Wicks with Columbia Rd Ellicott City  
Nov 30 1983  
Ellicott City  
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMA-16 30M 2/80  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 5 2

1- FOR  
STATE  
REGISTRAR **EDGAR F. STERN**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edgar F. Stern</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 25 - 83</b>			2b. HOUR <b>1707M</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 15 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52 51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>auto</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>JESSUP</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dewey H. Stern</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose E. Miller</b>			13e. STREET ADDRESS <b>Jessup Md. 20794 8295 WASHINGTON BLVD.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219 28 1205</b>		17. INFORMANT ADDRESS <b>Gloria E. Stern 8295 Washington Blvd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>L Kuch</b>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEVAN KUCK</b>			22e. ADDRESS <b>HOWARD CO. GENERAL HOSPITAL COLUMBIA MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>					4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CONTINUE TO PAGE 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. CONTINUE TO PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 0 4 5 3	
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond R. Sullivan</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11/27/83		2b. HOUR 5:20 P	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 20, 1908</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>75</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>11/27/83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5474 Delphinium Ct. -21045</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Sullivan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Simms</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>			
16b. SOCIAL SECURITY NO. <b>212-16-5412</b>				17. INFORMANT <b>Jerome McDermott</b>				ADDRESS <b>Ellicott City, Md. Farside Rd. 21043</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; Arteriosclerotic Cardiovascular Disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/28/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-30-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Joe J. Carver</i>	

NOV 29 1983



Male White Feb. 20, 1908 75

Maryland U.S.A.

U.S. Navy Petition

Maryland Howard Columbia x 2471 Delphinium Cr. - 21042

Thomas Salween Sarah Anne Elliott City, Md.

Van 767 21 212-4-2412 Jerome Holcomb - 11750 Female No. 21043

767 21

11-20-63  
1020 York St.  
The Towson Animal Home, Inc. Towson, Md. 21204

21042 Baltimore Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 12 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30454			
1- FOR STATE REGISTRAR JOHN EDWARD TOTTEN				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>John Edward Totten</b>				2a DATE OF DEATH MONTH DAY YEAR <b>Nov. 30, 1983</b>		2b HOUR <b>10:30 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 25, 1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>	
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien Nursing Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LT. Col.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>Columbia</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Leo F. Totten</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle F. Force</b>		13e STREET ADDRESS <b>6308 Sun High Pl. 21045</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>WW 2</b>		17 INFORMANT <b>Robert L. Totten</b>		ADDRESS <b>Same as # 13</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac pulmonary arrest</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>not known</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION _____		19b CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 _____		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>1982</b> , 19 _____, to <b>11/30</b> , 19 <b>83</b> , that (I) (we) lost <b>11/23</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>J. SEALS</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>12/1/83</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. SEALS</b>				22e ADDRESS <b>11085 Little Patuxent Pkwy. Columbia Md. 21044</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>12/6/83</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>	
24 FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>				25a DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	
5555 Twin Knolls Road, Columbia, Md. 21045							

BP

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Rignal G Waters</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 18 1983</b>			2b. HOUR <b>11<sup>30</sup> AM</b>				
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 14 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD</b>				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Distilling</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10095 Route 99 21043</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lot Waters</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Blanche Chainey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Mrs. Edith Waters (Same as #13.)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a. <b>Bacterial Pneumonia</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost (b) <b>Consecutive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b> <b>Years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a: <b>Disseminated Infection</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 11</b> , 19 <b>83</b> , to <b>Nov 18</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Nov 18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. J. Levine</b>					DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/18/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Levine, M.D.</b>					22e. ADDRESS <b>10802 Hickory Ridge Rd, Columbia Md. 21044</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>11/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) <b>Paul Cecil Welch</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-29-83</b>			2b. HOUR <b>10<sup>50</sup> PM</b>	
3. SEX <b>m</b>		4 RACE <b>w</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-07-22</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ho. Cty. Gen. Hosp. ER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Clarksville</b>				13d. INSIDE CITY LIMITS? <b>NO</b>		13e. STREET ADDRESS <b>11232 Johns Hopkins Rd</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thaddeus Eugene Welch</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Hall</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>WW 2 217-4-5827</b>		17. INFORMANT ADDRESS <b>M. Engle Ho. Cty. Gen. Hosp ER</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Terri Gershon</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>11/29/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Terri Gershon</b>			22e. ADDRESS <b>Howard County Genl Hosp. ER</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>Dec 2, 1983</b>			23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN</b>			23d. LOCATION CITY OR TOWN COUNTY <b>West Friendship Md.</b>		
24. FUNERAL DIRECTOR <b>Donald H. Gershon</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1983</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30457

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM HARVEY WHALEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 20 83</b>		2b. HOUR <b>P M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>02 07 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OKLAHOMA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>HARWOOD PARK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6409 FORREST AVENUE, 21227</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLAY PRESSER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GEN. ELECTRIC</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND HOWARD ELKBRIDGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL WHALEY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MYRTLE SIMS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>409-01-5480</b>		17. INFORMANT ADDRESS <b>ERMA E. WHALEY 6409 FORREST AVENUE, 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic lung disease, obstructive</b> <b>5010</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>asthma and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Silicosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Squamous cell carcinoma lung</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>81</b> , to <b>11-20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Laurence R. Gallagher, M.D.</b>				22c. DATE SIGNED <b>11-22-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAURENCE R. GALLAGER, M.D.</b>				22e. ADDRESS <b>ST. AGNES MEDICAL CENTER, 21229</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN MEM. GAR.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE HOWARD MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 4 5 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Michael Abraham Witcher		11/7/83		7:50 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	Black	Sept. 2 1950	33 YRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	13. STREET ADDRESS	14. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	Jessup	Rt. 1 and Montevideo Rd.	Direc.-Housekeeping	21045 Nursing Home	Howard County
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
Maryland	Howard	Columbia	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?	17. SOCIAL SECURITY NO.	18. INFORMANT	
Abraham	Witcher	Vietnam	231 68 4307	Jacqueline C. Witcher - Columbia, Md.	
PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) Multiple Injuries		
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.			(b) DUE TO, OR AS A CONSEQUENCE OF		
			(c) DUE TO, OR AS A CONSEQUENCE OF		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TO PART 1 OR PART 2)	
6:45xx 11/7/83		driver in auto/truck impact			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
highway		Rt. 1 & Montevideo Rd., Jessup, Howard Co., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		11/7/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11/14/83		Crownsville Vet. Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Nutter and Sons		NOV 9 1983		John J. Gwalt	
Funeral Home, Inc.		25c. ADDRESS			
2501 Gwynns Falls Parkway		Baltimore, Md. 21216			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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